Health Services
LOS ANGELES COUNTY

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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

June 9, 2011

TO: Supervisor Michael D. Antonovich, Mayor
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **STATUS REPORT ON THE PROPOSED PLAN TO IMPLEMENT THE 1115 MEDICAID WAIVER INITIATIVE**

On November 16, 2010, your Board directed the Chief Executive Officer (CEO), the Interim Director of the Department of Health Services (DHS), and the Directors of Mental Health and Public Health to report back to the Board within 30 days and monthly thereafter on a proposed plan to implement the Medicaid Waiver (Waiver). The proposed plans should include descriptions of the following: 1) the Low Income Health Programs; 2) payment methodology to private providers that will be included in the Waiver program; 3) protocols for the performance-based Incentive Pool; 4) drawing down Safety Net Care Pool uncompensated care funds; 5) partnership with LA Care to move seniors and persons with disabilities into managed care; 6) preparation of workforce to implement the Waiver; 7) pressing outside technical assistance needs to ensure the County can immediately take advantage of this Waiver; 8) enrollment, revenue, and expenditure projections; 9) monitoring of implementation efforts; 10) implementation timeline for system and infrastructure developments needed to comply with milestones and expectations established by the Waiver; and 11) integration of health, mental health and alcohol and substance abuse programs.

In addition, on December 7, 2010, your Board directed the CEO and the Directors of DHS and DMH to work with the Association of Community Human Service Agencies and the Community Clinic Association to report back to the Board within 60 days on a timeline and process to identify program sites to pilot the concept of patient-centered behavioral health care homes. Subsequently, we were also asked to include the California Association of Alcohol and Drug Program Executives. As this is related to the Waiver implementation plans, this item will be addressed in the monthly updates provided for the motion outlined above.

The CEO initially reported to your Board November 31, 2010, with updates dated January 31, March 10, April 6, and May 5, 2011. This status update represents our efforts for the month of May 2011.

WAIVER INITIATIVE

PROPOSED IMPLEMENTATION PLANS

LOS ANGELES COUNTY

Waiver Element/Plan	Status
1. Low Income Health Programs (LIHP): • Proposed scope of health, mental health and alcohol and drug benefits; • Eligibility requirements; • Enrollment, disenrollment and redetermination procedures or limitations; and • Identification and movement of eligible residents into coverage as efficiently as possible.	DHS submitted its LIHP application to the State on February 14, 2011 and received a letter of Initial Approval on April 11, 2011. The next step is an Authorization Process to ensure that program requirements will be met, and a Contract Process that will continue on a concurrent track with the Authorization Process. To date the authorization process has included documentation of the provider network, geographic access, cultural sensitivity, and Due Process policies. DHS will implement its program on July 1, 2011. DHS is building upon its existing Healthy Way LA (HWLA) program, which currently has 65,000 active members who will be grandfathered into the new program. This program currently meets some LIHP requirements and will provide the framework for the County's Medicaid Coverage Expansion (MCE) program. Eligibility requirements for enrollees are set forth in the Waiver's Standard Terms and Conditions (STCs). Enrollment and redetermination procedures will comply with State requirements. The DHS Ambulatory Care Team is developing and implementing an implementation plan for the MCE, to meet the required scope of services and access standards. DHS does not plan to implement a HCCI program at this time, due to low numbers of potential members and costs associated with meeting program requirements. DHS will revisit this issue for future years of the LIHP. Consistent with the LIHP application submitted to the State on February 14, 2011, mental health services will be available to HWLA members effective July 1, 2011. The mental health delivery system will operate through a carved out network of specifically designated mental health programs operated by DMH through directly operated and contracted programs. HWLA's mental

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	health benefit includes the full range of Medi-Cal reimbursable mental health rehabilitative services based on medical necessity. DHS and DMH have conducted a data match to identify patients using services in both departments; these patients will be given priority for enrollment in HWLA. A train the trainer session was held on February 10, 2011 for DMH staff on HWLA eligibility requirements and enrollment procedures. DMH staff will work with eligible patients needing special assistance to ensure successful enrollment. DPH decided not to include substance abuse benefits in the LIHP at this time; however, the departments will continue to pursue integrated services outside the scope of the LIHP. See below for additional information on mental health benefits in the LIHP.
2. Proposed payment methodology to private community clinics, hospital partners, and any other providers, including description of how payments will encourage and reward best practices and will ensure that an adequate network of providers exists.	Following the STCs, private community clinics with Federally Qualified Health Center (FQHC) or FQHC look-alike status will be paid according to the Prospective Payment System for services provided to HWLA members. Existing PPP contracts, HWLA contracts and SB 474 contracts will all require revision. Discussions with the PPPs have been productive and include the payment methodology and other contract provisions. Contracts were on the June 7, 2011 Board agenda and continued to the Board agenda of June 14, 2011. Non-network private hospitals will be reimbursed for emergency and post-stabilization care provided to HWLA members. DHS is finalizing negotiations with Antelope Valley Hospital and Santa-Monica-UCLA Medical Center. On February 22, 2010, the Board approved delegated authority to the Director of Health Services to complete and execute these agreements, subject to approval by County Counsel and the Chief Executive Office (CEO). DHS has not been able to complete negotiations for with a private hospital for scheduled inpatient services for patients residing in the east San Gabriel Valley. Thus, on June 7, the Board approved delegated authority to enter into transportation services for these

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	patients. Since payments to FQHCs are based on per visit rate, they do not encourage and reward best practices. DHS will explore the possibility of moving to a bundled or capitated payment. For the LIHP, DHS and Community Partners (CPs) are discussing alternative payment methodologies that may be permitted under the Waiver.
3. Protocols for annual Delivery System Reform Incentive Payment Pool (DSRIP), including performance measures around infrastructure development, innovation and redesign, population-focused improvements and urgent improvements to care.	DHS developed its DSRIP milestones to align with CMS goals and to prepare the Department for healthcare reform in 2014. All four DSRIP categories have been finalized by CMS; DHS submitted its proposal for three of the four categories on February 18, 2011. DHS identified a total of eleven projects (each containing several milestones) across these three categories: 1) Implement and utilize disease management registry functionality; 2) Enhance urgent medical advice; 3) Enhance coding and documentation for quality data; 4) Enhance performance improvement and reporting capacity; 5) Expand medical homes; 6) Expand chronic care management model; 7) Integrate physical and behavioral health care; 8) Improve severe sepsis detection and management; 9) Central line-associated bloodstream infection prevention; 10) Reduce complications of surgical procedures; and 11) Venous thromboembolism prevention and treatment. The fourth and final category has been finalized based on negotiations between CAPH, the State, and CMS, with input obtained from DHS. Reporting requirements for this category are standardized across all public hospitals in California and include metrics in the following areas: patient experience; care coordination; preventive health; and at-risk populations. The patient experience milestones will require DHS to measure and report outpatient satisfaction in a consistent manner across all hospitals using CG-CAHPS, a widely accepted survey tool. Milestones within the care coordination, preventive health, and at-risk population categories will require

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	DHS to expand its capabilities in collecting and reporting outpatient quality data. The Demonstration Year 6 (FY 2010-2011) year-end report was submitted to the State on May 15, 2011. Demonstration Year 7 will begin July 1, 2011.
4. Plans to draw down the Safety Net Care Pool (SNCP) uncompensated care funds, including plan for coverage of individuals between 133 percent and 200 percent of the Federal Poverty Level, to sustain payments to providers until the new Martin Luther King, Jr. (MLK) hospital is fully operational and to claim federal financing for workforce development programs funded by community colleges and universities.	The programs funded from the South L.A. Fund will continue until the new MLK hospital is fully operational. These include impacted hospital payments, PPP augmentations, strategic initiatives, and funding for operation of the MLK Multi-Service Ambulatory Care Center. Funding for these services will come from the Safety Net Care Pool and the Medicaid Coverage Expansion. DHS does not plan to implement a HCCI program at this time, due to low numbers of potential members and the costs associated with meeting program requirements. DHS will revisit this issue for future years of the LIHP. The State has used all available existing workforce development programs in the state as the nonfederal share to claim Waiver funds. DHS has worked with the Worker Education and Resource Center [the SEIU 721-affiliated entity] to develop proposals for worker training for FY 2011-12 which support the implementation of the Waiver. The agreement for this was on the Board's June 7 agenda, continued to June 14, 2011.
5. Efforts to partner with LA Care to move seniors and persons with disabilities (SPDs) into managed care.	The State began mandatory enrollment of SPDs into managed care in June 2011, with a 12-month transition period. At the March 1, 2011 Board meeting, DHS obtained delegated authority to complete negotiations and execute agreements, effective March 1, with L.A. Care to implement managed care for SPDs. The County negotiating team (composed of representatives from CEO, DHS and County Counsel) has been meeting weekly with the L.A. Care team. The teams completed work on the two provider agreements, which were executed, effective May 1, 2011. The agreements contain the negotiated "Division of Financial Responsibility (DOFR)", and have the initial four-month contract period rates. Amendments

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	to the agreements will be needed when the next set of rates are announced by the State and when the State, the County and LA Care are able to negotiate a risk-sharing agreement.
6. Preparation of workforce to implement the Waiver, including manpower shortage areas, training needs, and flexibility to better align resources to rapidly changing environment.	Each of the key elements of the DHS strategic plan has been evaluated for its human resource and training needs. The new classification of Certified Medical Assistant was created and an exam is open for applicants. Other efforts currently underway are developing duty statements for care managers, care coordinators, and medical assistants, and identifying temporary staffing needs for HWLA enrollment. Training is completed for staff in the pilot medical home clinics and training is underway for the coaches who will help to spread the medical home model through the remainder of the system.
7. Technical assistance needed to ensure the County can immediately take advantage of this Waiver, including expertise needed to better integrate mental health and substance abuse related services with federal financing.	Senior leadership from each of the three departments (DHS, DMH and DPH) continues to meet to pursue integration of mental health and substance abuse-related services.
8. Enrollment, revenue and expenditure projections.	Existing HWLA members (approximately 65,000 active members with services in the past year) will be grandfathered into the new MCE program. Existing DHS and CP patients will be targeted for enrollment, with prioritization of homeless, General Relief recipients, and patients using both DHS and DMH services. Negotiations with LA Care were completed regarding the SPD enrollment into managed care. The key objective of the County is having approximately 30,000 patients assigned to DHS facilities as their primary care provider [with specialty and inpatient care], both through patient choice and assignment of those who do not choose. Effective June 1, 2011, 4,619 SPD L.A. Care enrollees were assigned to DHS for their primary care homes. DHS is offering community partners (PPP) who receive primary care assignments the opportunity to obtain specialty care from DHS facilities.

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9. Regular monitoring of efforts, including any need to establish a Waiver oversight office.	Monitoring of efforts and status reporting are being incorporated into the new Ambulatory Care division, using existing resources. The new Deputy Director for Strategic Planning is responsible for oversight of DHS-wide efforts to achieve DSRIP milestones and will be working closely with the leadership of each individual initiative to ensure DHS meets and reports on all milestones on time.
10. Implementation timeline for system and infrastructure developments needed to comply with milestones and expectations established by the Waiver.	The DHS Fiscal Outlook, presented on March 29, 2011, included the first projections of costs for Waiver investments and for the Electronic Health Record information system. These projections were also included in the DHS fiscal outlook presented on May 17. DHS staff continue to refine these numbers, which will be updated in subsequent fiscal outlook memos.
11. Integration of health, mental health and substance abuse programs, including the integration of care and plans for outcome tracking across all three systems.	Mental health services will be available to HWLA members effective July 1, 2011. The mental health delivery system will operate through a carved out network of specifically designated mental health programs operated by DMH through directly operated and contracted programs. HWLA members will have a mental health benefit that includes the full range of Medi-Cal reimbursable mental health rehabilitative services based on medical necessity. HWLA members with minimal or moderate mental health needs will preferentially receive mental health services through programs co-located at primary care sites or delivered through collaboration between mental health and primary care providers. Individuals with more specialized and intensive mental health services needs will mostly receive services in more specialized and usually separate mental health outpatient, inpatient, and residential settings in which the full array of mental health rehabilitation programs are available. DMH and DHS have begun implementing the co-located services through an integrated primary care/mental health prevention and early intervention (PEI) program. The program was implemented at El Monte Comprehensive Health Center (CHC) in December, 2010, Roybal CHC in February, 2011, and Long Beach CHC in March 2011. Mental health staff are co-located within each facility and are available to provide PEI services for HWLA members and other patients as capacity permits. This program will be expanded to three

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	additional DHS CHCs and Multi-service Ambulatory Care Centers. DMH also plans to contract with selected CPs to augment behavioral health training and services at those agencies. In order to expedite distribution of the funds, DMH will provide training support to CPs through amendments to current DHS CP contracts during the current Fiscal Year. DMH is preparing contracts with the CPs for ongoing service delivery funding beginning in Fiscal Year 2011-12. These contracts are the subject of recommendations in an A-4 Board memo for the June 14, 2011 agenda. HWLA members will be screened for possible mental health services needs within their assigned medical home. If the mental health screening is positive the patient will be referred to DMH providers for a mental health assessment. At DHS facilities with co-located DMH staff the mental health assessment will be conducted on-site. Depending on the mental health needs of the patient, the mental health services may also be provided on-site or at a DMH directly operated or contract site that provides more specialized and intensive mental health services. It is expected that a similar process will be followed in CP locations with integrated mental health services. HWLA members seen at DHS and CP sites without integrated mental health services will be referred to DMH directly operated or contracted providers for mental health assessments and services. DHS care coordination staff will work closely with DMH to track referrals and to share information between DMH and DHS providers to manage the care of patients. In addition, HWLA members who are already receiving DMH services will be identified and DHS care coordinators will work with DMH providers to share information and coordinate care when indicated. HWLA members may also receive services through the patient centered behavioral health home pilot program discussed below. DHS and DMH are meeting regularly to develop enrollment, referral, and care coordination processes. An operations manual for the delivery of specialty mental health services to HWLA members is under development. DPH decided not to include substance abuse benefits in the LIHP at this time;

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	however, the departments will continue to pursue integrated services outside the scope of the LIHP.
12. Timeline and process to identify program sites to pilot the concept of patient-centered behavioral health care homes.	DMH has conducted an initial survey to identify examples of patient-centered behavioral health care homes currently operating successfully in Los Angeles County. Concurrently, the Department initiated the implementation of the MHSA-funded Innovations Plan which will enable the Department to pilot several models for integrated behavioral health homes. Outcome evaluations will be conducted on these approaches which include an integrated mobile health team, an integrated clinic model and models proposed by underrepresented populations. Finally, in collaboration with DHS and DPH, a behavioral health home workgroup was convened. Workgroup members include DMH, DHS and Public Health staff, representatives of several unions, contract providers and social service representatives. During the first two meetings, participants identified core elements of behavioral health homes to be implemented in Los Angeles. The workgroup will meet for a final session to identify actions that can be initiated now in order to prepare Los Angeles County for the potential implementation of behavioral health homes in 2014.